Reducing hospital admissions with person-centred intermediate care

Keywords: Community services/Older people/Geriatric assessments/Frailty

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In this article...
- The challenges brought about by people living for longer with long-term conditions
- The Welsh model of intermediate care in the community
- How an acute clinical team delivers patient-centred care

Key points
1. People live longer but often have long-term conditions, and current health services are not well equipped to respond to their needs
2. Welsh government strategy aims to create integrated community services to bridge the gap between primary care and the acute hospital
3. There are 22 community resource teams in Wales which provide nursing, multidisciplinary and medical care in the community
4. The CRTs’ main goal is to assess and support people in their place of residence, avoiding unnecessary hospital admissions
5. The CRT is an example of a change in approach, moving from fitting patients into care processes to building care processes around patients

Nurses working in the community and primary care are central to meeting people’s health needs by promoting health, preventing ill health and managing increasingly complex cases.

In the UK, there are 14.9 million people aged 60 years or above (including 1.5 million who are aged 85 years or older) and 40% of people aged 65 or above have a long-term, life-limiting illness (Office for National Statistics, 2015). Brown (2008) described how we have tamed acute death to prolong life – for example, people who would have previously died from a heart attack now survive but can experience heart failure. It is estimated that death is now preceded by 10 years of ill health on average (Brown, 2008). The fact that people live longer means there are more degenerative problems combined with more chronic disease, which increases demand for care and treatment. This comes at a cost – with the added difficulty that we are living in times of budgetary restraint.

The health service is traditionally geared towards treating singular conditions with the development of many specialists departments in hospitals. This model does not work so well for people living with multiple conditions. As the literature makes clear, people who are frail will have complex needs. Their care is often poorly coordinated and transitions between home and hospital are often protracted and inappropriate.

Better integration and coordination of care are key to a viable health service. The concept of ‘prudent healthcare’ (Aylward et al, 2013) encourages us to create innovative services delivering care that is responsive to patients’ needs. However, developing services that meet all these conflicting demands is a huge challenge, and there is no ‘one-size-fits-all’ solution.

Welsh model of community care

There are many models of intermediate community care in the UK, and more are being developed. As their design is primarily influenced by existing services, they all differ, which makes it difficult to compare them and gauge their success against one another.

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Abstract
In Wales, community resource teams (CRTs) were set up in 2010 as part of a country-wide strategy to establish a structure of intermediate community care. In the county borough of Neath Port Talbot, the nursing division of the CRT is the Acute Clinical Team and delivers assessments and interventions in people’s place of residence. This article describes how this small team of nurses builds its care around patients’ needs and has successfully reduced the number of hospital admissions of patients aged 80 or older, while achieving high levels of patient and staff satisfaction.

Citation
In Wales, one of the objectives of the 2010 Primary and Community Services Strategic Delivery Programme (Welsh Assembly Government, 2010) is to stop fitting patients into care processes and, instead, build care processes around them. Patients are often pushed in and out of hospital because this is traditionally seen as the only solution when health or social circumstances deteriorate. The Welsh strategic delivery programme aims to create an organised model of integrated community services that act as a bridge between primary care and the acute hospital. As set out by WAG (2010): “Services will be focused on the holistic needs of the citizen and delivered by the NHS, LAs [local authorities] and other partner agencies working together.”

CRTs were created as part of this strategic delivery programme, to deliver an early-response service to people in the community, with the aim of preventing unnecessary hospital admissions. They bring together all the teams already working in the community into a coherent system under the multi-agency leadership of local authorities. They complement the work of district nurses, and are made up of a variety of professionals including social workers, physiotherapists, occupational therapists, pharmacists and nurses.

The 2010 Welsh strategic delivery programme also established a single point of access to all 22 CRTs in the country. Through this single point of access, referrals go directly to the most appropriate team within the CRT. Referrals are taken from GPs, the Welsh Ambulance Service Trust, other types of community teams (for example, mental health or district nursing) and secondary care services. The number of referrals continues to increase year on year – they increased by 32% from 2014 to 2015 – but continued growth at this rate will be subject to the constraints of staffing levels.

Acute clinical team

The acute clinical team (ACT) is the nursing branch of Neath Port Talbot CRT. It provides the nursing and medical elements of the care needed by each patient. In urgent cases, the team can assess patients within four hours of referral so care can be delivered promptly; this helps prevent further deterioration and alleviates the anxieties of patients and relatives.

The ACT covers Neath Port Talbot county borough, with a population of 140,490. It was set up in 2005, before the creation of CRTs, and is led by an advanced nurse practitioner and supported by a consultant physician and geriatrician. The team, based at Cimla Hospital, comprises:

- ANPs;
- A community mental health nurse;
- Staff nurses;
- Healthcare assistants;
- Clerical staff.

Staff currently include three ANPs (and independent prescribers), who are skilled and experienced in assessment, diagnosis and older people’s nursing. Another three team members are training to become advanced practitioners. All staff receive training, both formal and informal, which is considered fundamental to the provision of good-quality care.

The team culture is strong and positive, with the patient as its focus. Patients are considered partners in the management of their care and treated accordingly. Nurses are encouraged to be autonomous within their scope of knowledge and experience, and to escalate issues quickly when these are beyond their scope. The cornerstones of the service are:

- Safety of patients and staff;
- Timeliness of care;
- Avoidance of duplication and waste;
- Provision of equitable and effective evidence-based care.

Further team features that facilitate people-centred care are:

- Responsiveness – the team is responsive to patients’ needs, staff’s needs, the changing environment and new challenges;
- Reflexivity (in line with the Nursing and Midwifery Council’s revalidation requirements) – the team regularly asks patients, families and referrers for feedback and uses that to inform future planning of training and resources;
- Flexibility.

The ACT works to the NMC’s (2015) Code, which provides a safe framework for professional practice. It also responds to many features outlined in the WAG’s (2014) community nursing strategy for Wales, as it:

- Has expertise in working with older people;
- Provides well-organised care packages and facilitates timely discharge from hospital;
- Fills gaps in service provision while avoiding duplication of services;
- Makes a significant contribution to prevention.

The ACT keeps extensive quantitative and qualitative data on its patients. Some patients’ stories are recorded digitally; this helps us to promote our services, and can also encourage other patients to discuss difficult issues with us.

Referrals

Referrals are taken from primary and secondary care; most come from general practice, but we also receive some from district nurses, social workers, hospital nurses and consultants. Once we have accepted a referral, the team either shares or takes over clinical responsibility for the patient.

We accept referrals for anyone aged over 18 years, who requires urgent treatment in their own home that would have traditionally been given in hospital. A referral must not duplicate care delivery from another service, although it can be complementary. As an example, the district nursing service may be caring for a patient who develops cellulitis that is not responsive to oral antibiotics; traditionally they would have been admitted to hospital, but the ACT will work with the district nurses while the patient is acutely unwell. There are no other specific referral criteria.

Assessments and interventions

The ACT provides rapid assessments – including comprehensive geriatric assessments if needed – and clinical interventions in the person’s place of residence, be it their own home or a care home. The team uses its own multidisciplinary assessment tool (Box 1).

Interventions needed may include intravenous antibiotics or the supportive monitoring of fluid balance when a person is dehydrated. Every patient will have different needs and their care plan is arranged in conjunction with their wishes and those of their family/carers. If it becomes evident that treatment in their own home is not possible, the team can admit to the most...
Box 2. Challenges and learning points

Challenges
- As the service has become an established part of care in the community, capacity is becoming an issue as the demand is increasing year on year.
- Due to the skill base required, one of our biggest challenges is recruiting suitably qualified staff.
- Finding time for training and development.
- Communication – such as IT (eg, lack of mobile technology, staff using both paper and electronic records), incompatibility of systems, fragmentation of patient records across different departments.
- Risk management at all levels of service provision, including a risk assessment for all lone workers and each patient, and risk management for the service provision.

Learning points
- Referrers, staff and patients need to work together as a team.
- Building good, trusting relationships with referrers, patients, families/carers, colleagues and other services takes time, effort and energy.
- Trust and respect need to be earned; they are not a given.
- Processes and governance need to be transparent.
- Training and skills should not be compromised.
- Running a nurse-led service requires vision, leadership skills, investment in team members and support from senior management.

appropirate place, be it an acute hospital, a local hospital or a nursing home.

Outcomes

Referral numbers have been increasing year on year. From for 1 January until 30 June 2014, 416 referrals were made – that year on year. From for 1 January until 30 June 2015, questionnaires about the service were distributed; Table 1 gives an overview of the feedback received.

During the four-year period from 2011 until 2014, the number of acute medical admissions for Neath Port Talbot residents aged 80 years and over to local hospitals has fallen by 14%. This sits against a statistic across all counties in Wales of a 7% increase in admissions over the same period (data provided on request by the NHS Wales Informatics Service).

Box 2 highlights the main challenges we encounter and the learning points we can draw from our experience. In the summer of 2015, questionnaires about the service were distributed; Table 1 gives an overview of the feedback received.

Conclusion

Our team successfully provides care built around the holistic needs of a growing number of older people. Supporting patients with long-term conditions and complex needs, as well as involving them in the management of their care, has benefited not only for them and their families, but also for staff and the public purse.

The subtle change in approach can quietly revolutionise health professionals’ day-to-day work. Good care does not always have to cost more, and cost-effectiveness does not necessarily mean compromising on quality. Working differently can bring about different outcomes. We believe it is possible to deliver good-quality patient-centred care, even in this age of austerity.

References


For more on this topic go online...
- Using hospital at home to reduce admissions Bit.ly/NTHospitalAtHome

Table 1. Service feedback

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<th>Respondents (n)</th>
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| Patients (44/101) | - The rating for satisfaction with the service was 9.4/10 (10 being ‘excellent’).  
- Respondents felt they had been treated with dignity and respect.  
- Respondents felt happy with the staff who had cared for/supported them.  
- 43/44 respondents had a positive experience of the service. |
| Acute clinical team members (13/23) | - All respondents felt they worked well as a team.  
- All respondents felt trusted, valued and respected.  
- All respondents felt they worked with clear objectives.  
- Respondents felt confident about raising concerns, and that these would be addressed.  
- There was a high level of job satisfaction. |
| Referrers (53/445) | - 90% of respondents were satisfied with the service.  
- 90% of respondents said the service was reliable; those who disagreed had had a referral refused due to capacity issues.  
- 90% of respondents said the service prevented hospital admission - the remaining 10% were not sure if this was the case. |

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